Evaluation of Community Chaplaincy Listening (CCL) in a Community Mental Health Group

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Abstract

Background: The Community Chaplaincy Listening (CCL) service was nationally developed by spiritual care chaplains and is now operating in over fifty GP surgeries across Scotland. Previous research has indicated its positive impact on people's sense of wellbeing and recommended the further embedding of the service. Until this study, the service had not been delivered or evaluated with people attending community based mental health groups.

Aim: To evaluate the impact of CCL within a community based mental health support group.

Method: This was a pilot service evaluation, evaluating the impact of CCL on a patient reported outcome measure (PROM) with 12 participants, all of whom attended a mental health support group. All participants attended an individual CCL session and received a maximum of two sessions of CCL and a minimum of one. Participants were asked to complete the Scottish Spiritual Care (PROM); a questionnaire with both preset questions and a general free text box two weeks after engaging with the CCL. Summary statistics were conducted on the PROM survey responses to understand people's experiences of the service and its perceived personal impact.

Results: CCL is evaluated as beneficial by all who received it in this study. It has the potential to increase people's positive outlook, which was a reported outcome from ten people participating in this study. Larger scale studies are required to verify the reliability for the findings from this small pilot study.

***Key words*—assets, community, chaplaincy, listening, mental health, resilience.**

I. INTRODUCTION

Introduction

All healthcare professionals are required, as part of their practice, to take time to listen (Browning and Waite 2010). However, the current pressures in healthcare often does not afford the time for staff to spend time listening as much as they would perhaps like (Ogden, et al., 2004). For example, whilst many nurses perceive spiritual care to be fundamental to care, and attention to this aspect of care enhances the overall quality of nursing care, (McSherry and Jamieson, 2011) nurses report that pressure of time, and in some instances lack of a private space or general privacy, limits the availability and quality of spiritual care (McBrien 2010).

We know that views about factors important to recovery in psychiatric illness differ between patients, nurses and medical students (Goldfarb, et al., 1996).(Nothing is said about doctors here – maybe they should be mentioned even if it why they do not appear in the evidence base?)

Nurses and medical students tend to underestimate how important spiritual care is to patients (Goldfarb, et al., 1996). While this might be, in part, due to a lack of understanding of spiritual care by nurses and students in this particular study other studies have highlighted the issue is wider than this and that there is limited understanding of spiritual care among nurses and students (Catanzaro and McMullen 2001; MacLaren 2004) and evidence of a lack of emphasis on spiritual care. Many staff report a belief that being involved in discussions with patients around spiritual or religious issues, which the patients find supportive of their care, (Shojaei, et al., 2015) can be counterproductive to the treatment being delivered by staff, despite research showing that such concerns are not born out in practice (Shojaei, et al., 2015).

Overall, evidence indicates that there is sometimes a disconnect between the views of the professionals and patients over the place of spiritual care. Patients express a point of view in which spirituality and religion are essential for good practice in mental health and not just an optional extra (Dein, et al., 2010). In a study on self management of longer term depression, the participants who took part in focus groups and in-depth interviews stressed that those who were responsible for their care should be required to adopt a holistic view which included a spiritual dimension. That is, there needed to be a focus on building hope, meaning and purpose through the use of empathy, listening and sharing of control of care between health care professionals and client so that people could experience therapies being done *with* them rather than *to* them (Chambers, et al., 2015).

Spirituality and Mental Health

Traditional studies which endeavoured to show the relationship between mental health, spiritual care and religious interventions have tended to focus on particular conditions such as depression or anxiety (Ano and Vasconcelles 2005). These studies often over simplify the understanding of the spiritual and religious aspects in relation to mental health by looking from a purely religious angle (Ano and Vasconcelles 2005).

In relation to spiritual care and mental health, spiritual care is concerned with personal identity and transcendence that go beyond the mere practicalities of daily living. These may include religious observance but may also have a much broader meaning and include natural, altruistic or aesthetical ideas (Koenig, McCullough and Larson 2000).

It is recognised worldwide that in holistic health care models professionals must pay attention to a patient's spiritual needs (Shojaei et al., 2015). In Scotland, since 2008 spiritual care chaplains have been working collaboratively with the health service to develop and evaluate assets based listening services within GP surgeries. CCL is the use of active listening techniques that help to build personal resilience and enhance personal wellbeing (NES 2015). This is achieved by giving individuals who are accessing general practice care the time and space to explore their story and their personal assets and solutions with someone who has particular skills in spiritual care (NES 2015).

We take a wider view of spiritual care in this pilot study. NHS Education for Scotland (NES) published 'Spiritual Care Matters' (NES 2009) which sought to define and separate religious care and spiritual care. Although it does not claim to be a complete explanation, Spiritual Care Matters (NES, 2016) (Should this be 2009?)

defines spiritual care as being person-centred care, in one to one relationships, that makes no preconceived ideas regarding a person's life orientation or their personal conviction. It further defines Spiritual Care as seeking to help people "(re)discover hope, resilience and inner strength in times of illness, injury, transition and loss" (NES, 2016). (Should this be 2009?)

It goes on to define religious care as care given in the context of a particular set of shared beliefs and values and understood in the context of a faith community (NES 2016). Spiritual care is therefore understood as a more inclusive concept than religion (Dein, et al., 2010).

The role of other Health Care Professionals in spiritual care

Research into attitudes towards spiritual and religious care of staff working in mental health have pointed to an ambivalence to religion and spiritual care (Kehoe 1999) and the mention of the spiritual by patients has been found to generate doubt and created anxiety for staff (Kehoe 1999). Check this

Community Chaplaincy Listening

In their 2012 paper Mowat, Bunniss and Kelly describe the development of the CCL model. The model involves the patient being referred most commonly by the General Practitioner (GP) with delivery of CCL in the surgery. The chaplaincy listener meets with the patient and introduces them to the service, and the patient can then access the service for as many sessions as they require to tell their own story and then to consider issues that might arise. They also can discharge themselves from the service without explanation (Mowat, Bunniss and Kelly 2012).

An action research project used to establish an effective CCL service in NHS Scotland indicated that patients, GPs and practice managers valued the service highly. Patients reported their appreciation of having the opportunity to engage in a process that facilitated them to set the agenda and outcomes and move towards positive changes in their lives. All participants said they would recommend this service to people facing similar challenges as they were. Practice managers indicated that the service would be helpful in supporting people presenting with mental health concerns (Mowat, Bunniss and Kelly 2012).

These results were very encouraging, but limited by the inclusion of only four GP surgeries; a return rate of patient surveys of 36% from a small patient group (n=49) patients and limited time (3 months) within the action research to evaluate and refine the processes (Mowat, Bunniss and Kelly 2012).

A subsequent study into the CCL service based in GP surgeries has demonstrated its usefulness in supporting people's mental wellbeing. Feedback from 310 patients who had received the service from 15 healthcare chaplains highlighted the preventative health potential of the listening service (Bunniss, Mowat and Snowden, 2013.) Patients described it as a buffer before the next step i.e. change in medication, hospital admission and that it prevented them from deteriorating further (Bunniss, Mowat and Snowden, 2013.) Some patients who knew the signs of their own potential decline, reported the service helped them and a number of patients described how, after having previously accessed CCL they would want to try the service again before antidepressants were prescribed (Bunniss, Mowat and Snowden 2013). Using listening and narratives to enhance people's spiritual wellbeing and build resilience in communities appears to support people to cope with emotional challenges of life (Mowet, et al., 2013).

Both GPs and patients have reported the positive benefits of the CCL service for patients (Mowat, Bunniss and Kelly 2012). Specifically, Bunniss, Mowat and Snowden (2013) found that people who had used the service reported being able to shift their perspective, finding a purpose to go on, enhanced wellbeing and finding a way to cope (Bunniss, Mowat and Snowden 2013). Since the publication of these findings the service has grown and is available in over 50 GP surgeries across Scotland.

Evaluation of CCL indicates that people with lived experience of mental welling (Wellbeing?) issues commonly present to CCL services when they are made available (Bunniss, Mowat and Snowden 2013). We do not know however how effective this intervention is with this patient population specifically. This pilot study therefore sought to understand the effectiveness of CCL with people experiencing mental health problems in a community setting. We worked with a willing group of people with mental health conditions who were involved in a local group designed to support people with lived experience of mental health.

CCL was piloted in a community setting, with the aim to evaluate its effectiveness when delivered outwith its original intended setting. Most research into CCL has sought to understand people's experiences of this service. Such research has highlighted how it enhances mental well being and that those experiencing mental illness readily engage with it as a service. Such research has however focused on exploring the impact of CCL when delivered in GP settings, further to a referral from a GP. Its impact on patient reported outcomes when delivered in a community mental health group has yet to be explored.

This study sought to explore the effectiveness of the CCL in a community setting utilising the Spiritual Care Patient Reported Outcome Measure (PROM). The PROM was originally trialed as the Lothian PROM (Snowden, et al., 2012) and was evaluated mainly in the acute setting and subsequently adjusted and validated for use in all care settings in 2017 (Snowden and Telfer 2017).

Methods

Research Aim

The aim of this research was to evaluate CCL when offered to participants who have lived experience of mental health issues and who were part of a community group who support people within a local urban area.

Description of the intervention and study design

The intervention being evaluated was CCL. Clients were referred to CCL by the community mental health group project manager if they thought it to be an appropriate intervention. The CCL intervention provides a non-judgemental, empathetic and reflective listening experience enabling clients to develop assets from within their own story. Each CCL session lasted for up to fifty minutes and the clients were offered up to two sessions each. Each session was individual and the content was decided on by the client. The client was free to talk about whatever was on their mind for that particular session and was able to guide the conversation. The CCL listener was always the same person giving the client continuity.

We used the Spiritual Care Performance Reported Outcome Measure to understand the impact of this service in one community setting. The PROM is a questionnaire with both open and closed questions. Participants were invited by the project manager, of the community mental health group, to fill out the PROM questionnaire two weeks after having had access to CCL. The PROM took no longer than 10 minutes to complete. The service evaluation took place between March and May 2016.

Ethical Issues

This was deemed a service evaluation by the local ethics committee and therefore did not require formal NHS ethical approval. It was however being undertaken as part of a formal education programme and therefore ethical approval was applied for from the College of Medical Veterinary and Life Sciences Ethics committee, University of Glasgow and was granted 15th March 2016.

Permission to undertake this service evaluation was sought in writing from the project manager and permission was given. Clients who had accessed CCL were approached by the project manager and given the opportunity to participate in the study. The project manager issued the potential participant with an information sheet, the PROM questionnaire and a stamped, addressed envelope – addressed to the project manager. The PROM had no identifiable information assuring anonymisation of the process. If the client chose to return the questionnaire this was taken as implied consent to participate.

The study sample was a convenience sample derived from clients of the community project who had accessed CCL. Over the time of the study (two months) approximately thirty appointments were available for clients. Clients were offered a maximum of two appointments thus the envisaged sample size was between 12-15 clients. All adults (over the age of 18) who engaged with CCL were invited to take part in the research regardless of age, culture, social or gender status.

Data Collection Tool- The Scottish Spiritual Care PROM

The Spiritual Care PROM (Appendix I) has been developed as a tool to measure the effectiveness of Spiritual Care (Snowden, et al., 2012 and Snowden and Telfer 2017).

Data Collection Process

After clients had completed their CCL sessions they were offered the opportunity to participate in the study. They were approached by the project manager, who gave them the participant information sheet. If they were happy to proceed, they were given the PROM and an accompanying stamped addressed envelope. Clients were given the opportunity to complete the questionnaire in the centre or to take it away to be completed. Completed PROMs were mailed/ given to the project manager and kept in a secure cabinet until they were collected by the researcher.

Data Analysis

When analysing the data, each response was entered onto a spreadsheet and then summarised and analysed using descriptive statistics. Comments written in the free box were entered onto a spreadsheet and were coded and themed (Boyatzis 1998).

Results

Sample Characteristics

During the course of this service evaluation 18 clients were invited by the project manager to participate in the study. All of the clients were part of the mutual support group in a community mental health setting and each had received two sessions of CCL.

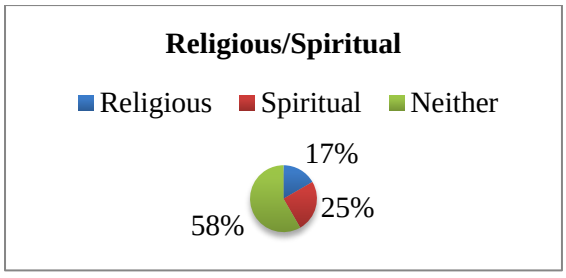
Of the 18 clients who were invited to participate, 12 (67%) agreed to participate and returned the completed PROM. The other six (33%) took the questionnaire but did not return it. We did not follow up clients with a repeat request.

Ten (83%) of the participants were female with an average age of 53 years (range 28-72 years). The remaining two (17%) were male with an average age of 67 years (range 62 - 72 years).

Religious and Spiritual Inclination

Seven (58%) participants described themselves as being neither spiritual or religious, three (25%) described themselves as being spiritual with the remaining two clients (17%) describing themselves as being religious.

Figure 1: Clients Reported Religious or Spiritual Inclination (n=12)



The clients' experience of CCL

The first set of questions within the Scottish Spiritual Care Patient Reported Outcome Measure (PROM) explored the experience of the clients when they met with the Chaplain providing the Community Chaplain Listening (CCL) service. The four questions relate to being listened to; being able to talk about what was on their mind; that their situation was understood and faith and beliefs valued. Clients were asked in the PROM about the experience of the CCL service and asked to reflect on how they felt at that time, rating their response as one of five Likert scale options; none of the time, rarely, some of the time, often or all of the time.

The figures below display the clients' responses from the first section of the PROM. The 'y' access represents the number of people replying to each question.

Figure 2: Clients' response to PROM Q1. During my meeting with the Chaplain I felt I was being listened to.

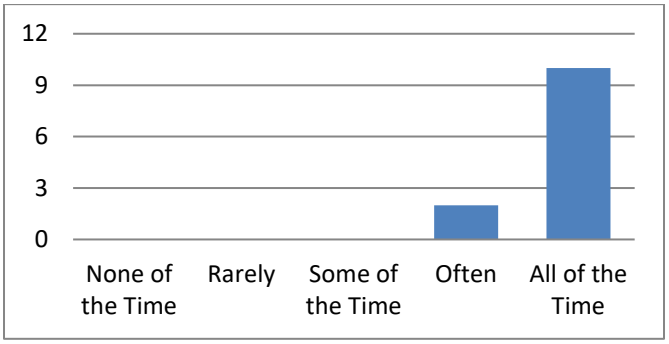


Figure 3: Clients' response to PROM Q2. During my meeting with the Chaplain I felt I was able to talk about what was on my mind

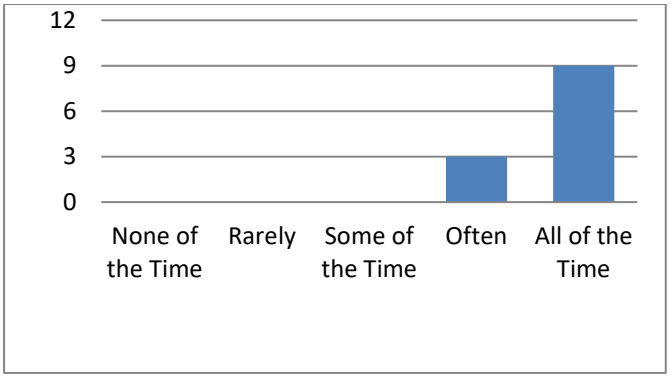


Figure 4: Clients response to PROM Q3. During my meeting with the Chaplain I felt my situation was understood

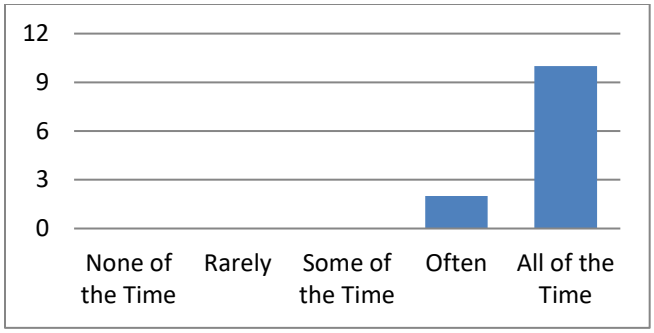
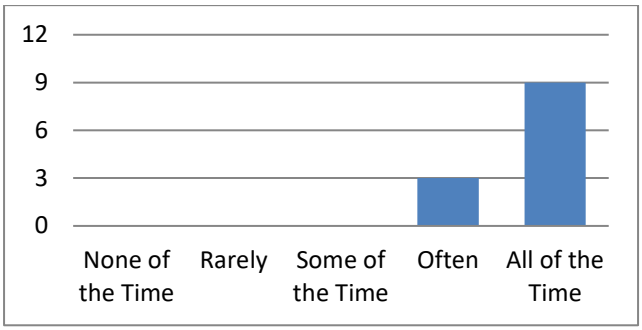


Figure 5: Clients response to PROM Q4. During my meeting with the Chaplain I felt my faith and beliefs were valued



In the majority of instances clients who shared their experience of CCL reported consistently high (figures 2-5) with an average of 79% of participants scoring 'all of the time' for each of the four questions, with the remaining 21% scoring 'often'.

Seven of the 12 participants commented in the free text section of the questionnaire, all of which were positive. The themes of these comments included “being listened to”; “understanding”; “honesty” and “time”. The participants reported that in “being listened to' (Q1.): "the listener....listens and tries to help you" (Client 1). A number of comments referred to being 'understood': "I felt the listener understood me" (Client 5); “He was a very understanding man who listened" (Client 7).

A number of people reported how easy it was to be honest: "It felt safe" (Client 3) and “You don't have to wear a face and you can be yourself" (Client 3). Lastly being given time was of great value to clients: "the length of time for the appointment makes a difference" (Client 1).

The clients’ self reported feelings after two weeks following CCL

In the second section of the PROM the questions consider the outcomes that are important to people receiving spiritual care. The clients were asked in the PROM to tick the statement that best described their experience over the last two weeks i.e. in the two weeks since receiving CCL; rating their response as one of five options; none of the time, rarely, some of the time, often or all of the time. This section of the PROM asked the client after meeting the chaplain if they could be honest about how they were feeling; their level of anxiety; their outlook on their situation; if they felt in control of their life and if they had a sense of peace.

The overall response to the questions in this section of the PROM indicated that all participants could be honest with themselves about how they were really feeling at least some of the time with half reporting this to be the case all of the time (Figure 6).

Figure 6: Clients response to PROM Q5. In the last two weeks I have felt I could be honest with myself about how I was feeling.

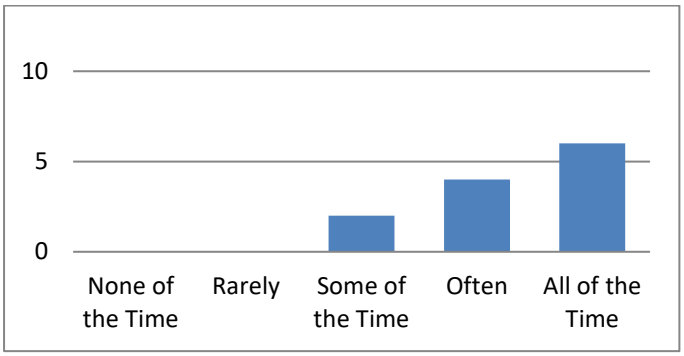


Figure 7 shows that the half of the participants (n=6) responded that they were 'anxious' 'some of the time. The others were divided equally between feeling anxious 'rarely,' 'often' or 'all of the time.'

Figure 7: Clients response to PROM Q6. In the last two weeks I have felt anxious

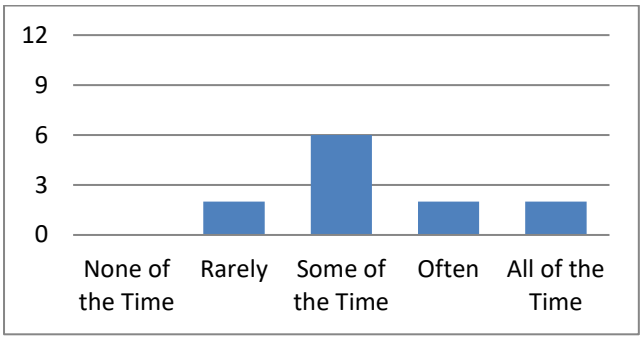
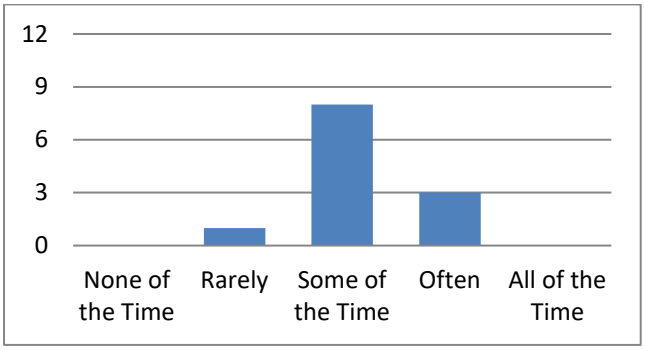


Figure 8 shows the majority of participants (n=8) responded that they had 'a positive outlook on my situation' with only one person reporting they rarely had a positive outlook and one reporting that they often had a positive outlook.

Figure 8: Clients response to PROM Q7. In the last two weeks I had a positive outlook on my situation



In terms of being 'in control of my life' the majority of participants (n=9) responded that they were in control 'some of the time' with the remaining three responding with 'none of the time,' 'rarely,' and 'often' respectively (Figure 9).

Figure 9: Clients response to PROM Q8. In the last two weeks I have felt in control of my life.

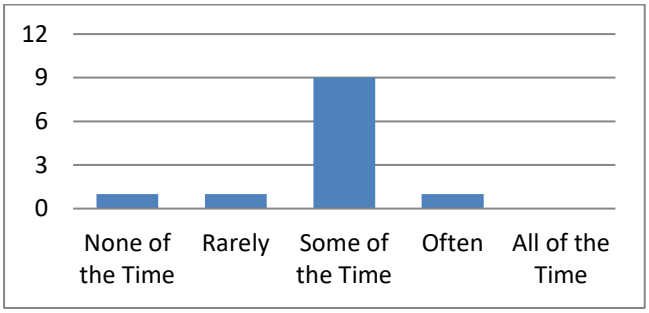
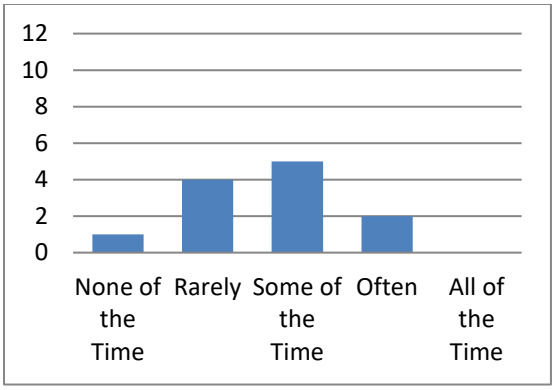


Figure 10 shows that no one indicated they had a sense of peace all of the time, only 2 reported to have this often; 5 some of the time; 4 rarely experienced a sense of peace and 1 person indicated that they never experienced it.

Figure 10: Clients response to PROM Q9. In the last two weeks I have felt a sense of peace



Free text responses

People still appear to be anxious following the CCL encounters and while we cannot compare this with how they would have scored prior to the intervention, free text comments allow us to identify aspects of the service that appear to be useful.

Participants in the free text reported that even though they were reporting high anxiety they none the less had benefited from accessing CCL. Participants reported that "he tries to help you (client 1), that "I feel better about myself" (client 5) and "If it wasn't working I wouldn't see him" (client 6). They also indicated that it supported them to better engage in heath (health?) decisions with their treatment team: "I benefitted greatly from the opportunity to be open and honest and feel that in doing so I was then more able to express myself to the treatment team" (client 12).

Free text responses indicated other significant benefits from engaging with CCL such as perceived ability to rationalise issues; perceived ability to heal; perceived ability to take part and influence own treatment plan; ease of access and normalisation. Participants reported that "It was like a black cloud being lifted from me" (client 4); "I'm glad this service exists……I can grow again, I was left behind" (client 11) and "I benefitted greatly from the opportunity to be open and honest and feel that in doing so I was then more able to express myself to the treatment team" (client 12).

Access and de-stigmatisation of health issues were also perceived as positive features of the service. One participant reported that there was "Easy access to the service" (client 7) and another reported that the opportunity to access CCL "de-medicalises the process" (client 1).

Overall, participants reported positive effects of attending CCL sessions: “It was like a black cloud being lifted from me" (client 4) another reported "I'm glad this service exists…..I can grow again; I had been left behind" (client 11). These statements provide evidence that CCL can influence people’s outlook and ability to cope after only two sessions.

The results provide evidence that CCL was well received by participants, had a positive impact on people's wellbeing and helped people develop a more positive outlook.

Discussion

The clients' experience of the Community Chaplaincy Listening (CCL)

PROM results showed that CCL consistently created an environment where clients who were accessing a community based mental health service felt listened to, able to talk about what was on their mind and to feel like their situation was understood and their faith and beliefs were valued. This is consistent with findings from other studies examining the effectiveness of spiritual care provision in inpatient settings (Snowden, et al., 2012), or in community settings through the CCL model of listening (Bunniss, Mowat and Snowden 2013).

The results of the current study demonstrated that all participants benefited to some extent from the intervention by the chaplain, regardless of their stated religious inclination. This further endorses Snowden, et al's conclusions in 2012 that spiritual care is an essential service for religious people, but just as important for the non-religious.

Participants in our study reported being able to talk about what was on their mind. They also reported the benefit of the longer, on average 50 minute appointment. The pressure in the health care system often limits the time that some health care workers are able to spend with people (Ogden et al., 2004; McBrien 2010). The CCL model therefore provides a way for health services to provide the time to address spiritual needs and offer person-centred care (Mowat, et al., 2013).

Our study also highlighted that CCL often placed the person in a space that facilitated them to be heard and understood. When considering improvement in healthcare Brandrud, et al. (2011) suggested that one of their three recommendations for quality improvement was the listening process, especially as the patient travels through their healthcare journey. Gaur et al. (2011) suggested that healthcare organisations require to re-think how they deliver their services to consider a shift from a purely treatment perspective to a more collaborative approach, because patients want healthcare professionals to be more caring and interactive in how they are being dealt with.

This active listening and understanding takes a shift in mindset for the health professional that allows them to be more person-centred i.e. to be sympathetically present with the individual; engaging in ways that recognise the uniqueness and value of the individual, by appropriately listening and responding to cues that maximize coping resources through recognition of important agendas and values in their life supporting the (McCormack and McCance, 2017). CCL supports people to build trust and hope in caring relationships and encourages a more

collaborative approach in consultations (Chambers, et al., 2015) and thus the techniques used within it are important in providing person-centred care.

The effect of the CCL felt by clients after two weeks

Having the service provided in a community setting was important to clients, making it easy to readily access. Other clients talked of the importance of the service being delivered in places that "de-medicalises the process" (client 1). Evidence highlights how important this is to those living with mental health conditions (Brandrud et. al., 2011; Gaur et. al., 2011) and therefore is a key consideration when designing the provision of this service.

This pilot study has indicated that CCL can produce a positive outlook for those who have accessed the service. The service assisted people in talking about their feelings and in playing a greater part in treatment planning with their health care practitioner. Findings from this study add to the growing understanding of the positive association of spiritual issues, where patients who have had their spiritual needs addressed report better mental wellbeing (Wong, Rew and Slaikeu 2006) and similarly report lower levels of depressive symptoms (Mihaljevic´, et al., 2015) therefore CCL can play a useful role in assisting clients who are experiencing depressive conditions.

Study limitations

The study has some limitations. The sample size was small and the study was only conducted on one site therefore the results cannot be generalised to all those with mental health problems or indeed other health conditions accessing CCL services. The sample was also too small to meaningfully compare the responses of those who described themselves as spiritual, religious or neither. Further, due to the age range of the study group there was insufficient data to be able to analyse whether the age of the participants made a difference to people's reported experiences (Schmidt and Hunter 2015). Finally, all those who had accessed CCL during the study period were given the opportunity to participate in this study and 6 (33%) chose not to. We did no comparison of demographic characteristics between non responders and responders therefore, we cannot detail any non- responder bias. Lastly, the PROM has not been used to understand difference in people's outcomes before and after CCL. Studies using this approach would strengthen the evidence of effectiveness of this intervention.

Conclusion and Recommendations

CCL could offer a potential solution to health professionals (Ogden, et al., 2004) working in the primary care setting who often find they have constraints on the time that they can give their patients. CCL is a service which provides listening as a fundamental element of the intervention, and thus provides patients with the time and dedicated listening they might need (Mowat and Swinton 2007). Our findings detail its important role in promoting wellbeing for those experiencing mental health symptoms and is therefore a useful service that can enhance the NHS's ambition of providing care that is more person-centred (HIS, 2017).

Recommendations for practice

In healthcare, referrals to specialists, such as psychiatrist (and psychologists often have long waiting times. CCL can offer a therapeutic solution while people wait or provide an alternative for some, thus easing the pressure on other aspects of the service that are under significant pressure. CCL could be developed and provided in other services as a way of addressing spiritual needs and enhancing person-centred care.

Recommendations for Education

There is a requirement for better understanding around the role of spiritual care within modern healthcare as there is often a misunderstanding of its place by healthcare professionals and therefore a lack of referral to such support for those who might benefit. There is also potential to educate health care professionals in using the techniques more routinely in their practice so that they can be more sympathetically present with people when in distress.

Further research

This study was a small pilot, with no control group. In order to develop stronger evidence of the effectiveness of CCL in community settings larger studies are required. Knowledge of the effectiveness of this intervention could also be enhanced by multi-site research, a before and after controlled study design or an RCT between CCL and "usual care" and the use of other patient outcomes such as symptoms, quality of life and social functioning related to specific mental health conditions. It is also unclear what the ideal "dose" of CCL is or for how long its effect might last therefore a controlled, longitudinal study evaluating the impact of CCL delivered in different doses would help understand the optimum number of sessions and understand how long any impacts last.

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The Scottish Spiritual Care Patient Reported Outcome Measure ©

NHS Education for Scotland

This questionnaire has been designed to measure the outcomes of spiritual care.
Please answer the following questions.

Name/ID: Age:

Please tick all that apply

	Male	Female	Other
I am	○	○	○
	Religious	Spiritual	Neither
	○	○	○

This first set of questions asks about your experience when you met with the chaplain. Please think about how you felt at that time. For each statement please tick the box that best described your experience.

During my meeting with the chaplain I felt...

	None of the time	Rarely	Some of the time	Often	All of the time
I was listened to	○	○	○	○	○
I was able to talk about what was on my mind	○	○	○	○	○
My situation was understood	○	○	○	○	○
My faith/beliefs were valued	○	○	○	○	○

This next set of questions covers the outcomes that seem to be important to people receiving spiritual care. For each statement please tick the box that best describes your experience over the last two weeks.

In the last two weeks I have felt...

	None of the time	Rarely	Some of the time	Often	All of the time
I could be honest with myself about how I was really feeling	○	○	○	○	○
Anxious	○	○	○	○	○
I had a positive outlook on my situation	○	○	○	○	○
In control of my life	○	○	○	○	○
A sense of peace	○	○	○	○	○

Please add any further comments you wish to make below. Please continue overleaf if you wish. Thank you.